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HEALTH INSURANCE FOR CHILDREN

Private Individual Coverage Available, but Choices Can Be Limited and Costs Vary

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The Honorable Anna Eshoo
The Honorable Frank Pallone
Cochairs, Democratic Caucus Children's
Health Care Task Force
House of Representatives

The Honorable Sherrod Brown
Ranking Minority Member
Subcommittee on Health and the Environment
Committee on Commerce
House of Representatives

The Honorable Elizabeth Furse
House of Representatives

In 1996, nearly 10.6 million children—about 14 percent of all U.S. children—did not have health insurance coverage. The largest group of children without coverage are from low-income working families. Some of these children are not eligible for Medicaid or other public programs, and their parents may not have access to employer-based coverage. For these families, the cost of private health insurance and their inability to qualify for Medicaid or other public programs present significant barriers to access to coverage. To increase the number of children with insurance coverage, the Congress appropriated almost $40 billion over the next 10 years through the Balanced Budget Act of 1997, under title XXI of the Social Security Act. This funding, primarily targeted for state children's health insurance programs, is intended to improve access to coverage for uninsured children from low-income families—either through an expansion in Medicaid or the development of other state initiatives.

In addition to these public program approaches, the Congress has expressed interest in the availability of private sector health coverage for children in the individual insurance market.[1] Accordingly, you asked us to (1) describe the availability and characteristics of private health insurance products that can be purchased only for a child and how these products differ from other individual private insurance products, (2) determine the

[1]While most Americans obtain health insurance coverage through employer-sponsored group plans or government programs like Medicare and Medicaid, a significant minority purchase health insurance individually for themselves and their families, which we refer to in this report as the private individual insurance market. For more information about the individual insurance market, see Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs (GAO/HEHS-97-8, Nov. 25, 1996).

costs of these child-only products, and (3) identify any barriers in access to individual private health coverage for children.

For the purpose of our study, we define a child-only product as a comprehensive medical policy[2] that can be purchased for a single child—without an adult on the policy—in the individual insurance market. In addition, we define a child-rated product as one that is priced specifically for enrollees under the age of 18 or 19 years. We identified about 20 carriers that offer child-only coverage by contacting representatives from insurance trade associations and research organizations and obtained information about the availability of their products nationwide. In addition, we collected information about the characteristics of these products, including their benefit structure as well as their cost nationwide and any barriers to access, by conducting in-depth interviews with seven of these carriers, including three multistate carriers, two single-state carriers, and two regional HMOs.[3] The plan types of these seven carriers included traditional indemnity fee-for-service (FFS) plans, preferred provider organization (PPO) options, and HMOs.[4] We did not independently verify the premium prices of the three carriers in our study that did not provide us with published rates.

To determine consumer awareness of products available to children only, we tested the awareness of insurance agents and brokers, since they may likely be a consumer's first point of contact in locating a child-only product. To do so, we contacted over 100 agents and brokers who sell health insurance in both Georgia and Illinois.[5] We also reviewed published literature on children's insurance and the individual insurance market. We conducted our review between January and June 1998 in accordance with generally accepted government auditing standards.

[2]Our study focuses on private comprehensive individual major medical and health maintenance organization (HMO) products and does not include other health insurance products, such as hospital and medical expense plans, accident, or other supplemental medical plans that may be offered for children. In addition, the study does not include products offered through public and private subsidy programs.

[3]Our study does not include all carriers that may offer coverage to children in the individual health insurance market.

[4]PPOs are health benefit arrangements through which patients can obtain services at lower costs by using a selected network of health care providers with whom the PPO has negotiated reduced payment rates for services. PPO members can obtain covered services delivered by nonnetwork providers but may be responsible for higher levels of coinsurance, copayments, and deductibles for using nonnetwork providers.

[5]We judgmentally selected two states that do not guarantee coverage to everyone or restrict premium rates in their individual insurance markets.

Results in Brief

Comprehensive health coverage is available to children in the individual health insurance market across the United States. At least one comprehensive product is available to most children in all 50 states. In almost all states, a product that is priced specifically for children is available. The insurance agents and brokers we contacted in two selected states were generally aware that products for children existed and could either sell the products themselves or refer us to someone who could. The benefits covered under these products typically mirror those of products available to adults in the individual market. While these products were available nationwide, among the carriers we contacted, they represented a relatively small share of total individual sales—from under 1 percent to 20 percent. Furthermore, since many carriers do not tend to operate in states with certain regulatory requirements, consumers may have a more limited choice of benefit plans and carriers in these states.

As is the case with products for adults in the individual market, costs for child-only products varied considerably, both within and across selected markets. Standard monthly premium rates for the products we reviewed that are available to children are based largely on age; geographic location; plan type, such as managed care or FFS plans; and product design, including deductible and cost-sharing options. In calculating rates, carriers also take into account the expected health care utilization of different age groups and the impact of various state regulations. We found standard monthly premium rates for a healthy 15-year-old among our selected carriers ranged from a low of about $42 for a $1,000 deductible PPO plan in Portland, Oregon, to one as high as $321 for a $250 deductible FFS plan in Los Angeles, California.

While these child-only products are available in all states—as is typical in the individual insurance market—many states do not require carriers to accept all applicants. In these states, children with certain health conditions may be denied coverage, or their coverage may exclude an existing condition or treatments for particular parts of the body, or they may be charged a rate higher than the standard premium rate. Of the carriers that we reviewed, two that market specifically to children do not cover children under these policies during their first 6 or 12 months of life, due to the high cost of early preventive care and lack of information about a child's possible future health problems.

Background

The majority of children—about 62 percent in 1996—obtain health coverage as dependents through their parents' employer-sponsored group plans. Most other children who are insured are covered by Medicaid, the largest public insurance program for children. The 14 percent of children without health insurance tend to be from families where one or both parents are unemployed, self-employed, or work for firms that either do not provide dependent coverage or offer this coverage at a price the parents consider unaffordable. In such cases, parents may purchase health coverage individually for themselves and their families. Since rates for family coverage in the individual market may be high relative to a family's disposable income, some parents opt to forego coverage for themselves and only purchase coverage for their children. Divorced parents who are required by court order to provide health insurance for their children and grandparents who are retired but caring for their grandchildren are examples of consumers who typically rely on the individual market to purchase health coverage for children.

Comprehensive Coverage Available to Children Nationwide, but Choice May Be Limited

Individual policies are available to children nationwide, and products that are priced specifically for children are available in almost all states. The benefit structure for child-only products was similar to comprehensive products typically available to adults in the individual market. However, the choice of carriers and products may be limited in some markets because many carriers perceive demand for child-only policies as low and, therefore, do not aggressively market this type of product. Furthermore, some carriers do not tend to operate in states with certain regulatory requirements.

Products Available Nationwide

As long as an adult is the policyholder and is responsible for the premium payment, almost all of the carriers we contacted in the individual market will sell a product that provides comprehensive coverage for a child only. We found that at least one individual comprehensive health insurance product is available to children in all 50 states. Furthermore, among the carriers that provided information, we found that at least five sold a comprehensive health product to children in the individual market of most states. In addition, we found that 49 states and the District of Columbia currently have at least one carrier that offers a product priced specifically for children—that is, child rated. Most insurance agents and brokers we contacted in Georgia and Illinois were generally aware that these products are available from a number of carriers. Approximately 91 percent of the agents we contacted in Georgia and 74 percent of the agents we spoke with in Illinois either sold the products or referred us to a carrier that did.

Benefits Available to Children Mirror Individual Adult Products

The benefit structure of comprehensive health products available to children was not notably different than products available to adults in the individual market. We found that comprehensive products available to children in our selected sample covered a wide range of benefits, including inpatient and outpatient hospital and medical and surgical services; emergency care; diagnostic services, such as laboratory tests and X rays; prescription drugs; and skilled nursing facility care. Most of these plans also included coverage for physical, occupational, and speech therapies; organ transplants; mental health; substance abuse; home health care; and hospice care. Similar to their adult products, two of the non-HMO multistate carriers—one of which marketed specifically to children—did not include as a core benefit preventive care, such as immunizations and well-baby visits. Coverage for these benefits is available from these two carriers but at an additional cost—ranging from $4 to $33 a month.[6] In addition, another multistate carrier limited the preventive care benefits in its individual product to $50 per member in a calendar year.

Choice of Products and Carriers May Be Limited

Although coverage is available nationwide, consumer choice among products and carriers may be limited in a number of states for at least two reasons. First, while many carriers are willing to offer their individual adult products to children, they perceive the demand for child-only policies as low and therefore do not aggressively market this product. Carrier officials told us that the adults who are likely to purchase this type of coverage represent a small share of individual purchasers. One multistate carrier reported that it has sold only a “handful” of child-only policies, while officials at other multistate carriers said they have about 7,000 to 9,000 of these policies currently in force nationally. Among the seven carriers we reviewed, child-only products represent a relatively small share of the carriers’ total individual health insurance sales—from under 1 percent to 20 percent. Further, since children’s products are often among the lowest priced individual products, the commission amount—which is usually based on a percentage of the premium—may not provide agents a strong incentive to actively sell these products.

Second, few carriers tend to operate in states with insurance reforms in place, such as “guaranteed issue” requirements and premium rate

[6]When we quote premium rates from these carriers in this report, we include the additional cost of preventive care to make the policies more comparable with products offered by other carriers.

restrictions.[7] Guaranteed issue requires all carriers that participate in the individual market to offer at least one plan to all individuals and accept all applicants regardless of their demographic characteristics or health status. Thirteen states require carriers to guarantee-issue certain products to all applicants. Twenty states include provisions in their legislation that attempt in some way to limit the amount carriers can vary premium rates in the individual market or the characteristics they may use to vary these rates.

Insurance industry representatives as well as some analysts and policymakers claim that these regulatory provisions can result in the tendency for individuals to wait to purchase insurance until medical care is needed. The potential result is "adverse selection," where a disproportionate number of individuals with high health care costs seek insurance, which increases the average cost of coverage for all those insured. While such reforms can benefit individuals who may otherwise have difficulty obtaining coverage, the combination of guaranteed issue and rate restrictions discourages some carriers from entering or remaining in such a market.

Costs for Child-Only Products Vary Considerably

Children's monthly premium rates may vary widely based on factors such as a child's age and local market and product characteristics. Carriers also take into account the expected health care utilization of different age groups and the impact of various state regulations in calculating their premium rates. For the products we reviewed that are available to children, we found standard monthly premium rates for a healthy 15-year-old among our selected carriers ranged from a national low of about $42 for a $1,000 deductible PPO plan in Portland, Oregon, to one as high as $321 for a $250 deductible FFS plan in Los Angeles, California. In 18 selected geographically dispersed urban and rural markets, we found that nearly half of the products had premiums priced at more than $80 a month for one child.

Even within particular markets, there were substantial differences in the premium prices of products that carriers offered. Table 1 illustrates some choices a consumer would encounter if shopping for coverage for one child in the individual insurance markets of certain cities. Although it is difficult to isolate one factor from another, the standard monthly premium rates generally vary based on the type of plan a consumer chooses and the

[7]For additional information about states that require certain products to be guaranteed issue or impose rating restrictions for products in their individual markets, see Private Health Insurance: Declining Employer Coverage May Affect Access for 55- to 64-Year-Olds (GAO/HEHS-98-133, June 1, 1998).

deductible a consumer is willing to spend up front as well as how the carrier rates its product. Even within a single geographic market, premium prices for child-only products varied considerably. For example, a consumer in Chicago, Illinois, who wanted to purchase health insurance for a healthy 10-year-old could choose from among at least five different products offered by four carriers, with monthly premiums ranging from $63 to $142. Even products that seemed similar differed in price—such as the child-rated, PPO products with a $250 deductible offered by Carriers A and B in Chicago, Illinois, which differed in price by $39 a month.

Table 1: Examples of Selected Carriers' Monthly Premium Rates for a Healthy 10-Year-Old in Several Markets

Carrier	Plan type	Deductible	How rated	Monthly premium: Chicago, Ill.	Cleveland, Ohio	Hattiesburg, Miss.	Omaha, Nebr.	San Francisco, Calif.
A	PPO	$250	Child-rated by age group	$63	NA	NA	NA	NA
B	PPO	250	Child-rated by age group	102	$82	$80	$61	$145
B	PPO	500	Child-rated by age group	83	67	65	50	118
C	FFS	500	Single-child rate	142	NA	120	66	NA
D	FFS	2,500	Lowest adult rate	103	68	62	55	NA
E	HMO	0	Child-rated by age group	NA	NA	NA	NA	52

Note: "NA" indicates the plan is not available in this market.

We identified several factors that affect monthly premium rates for child-only products: age and number of covered children in a family and their expected health care utilization; geographic location and state regulations; and plan type and design, including deductible and cost-sharing options.

Age, Number of Children, and Expected Health Care Utilization

The seven selected carriers in our study priced their products using age and number of children covered from the same family in one of three ways:

- four carriers used a child rate that was tiered according to specified age groups,
- two used a single child rate for all enrollees aged 0 through 17 years, and

- one charged its child enrollees the lowest adult rate—that of an 18-year-old male.

In the last case, when more than one child from the same family was covered, the carrier charged a combination rate, whereby the youngest child paid the lowest adult rate and additional children paid a lower, child's rate. Insurance industry officials told us that charging a child rate as opposed to the lowest adult rate can reduce the premium for most children. This is because children are typically low users of health care services compared with adults and therefore are less expensive to insure.

Some of the tiered child-rated products were priced differently to take into account the specific age of the child. While children overall are typically low users of health care services compared with adults, some age groups tend to use more services than others. For example, carrier officials stated that children under age 2 tend to be high users of health care services due to the number of immunizations and physical exams recommended by the American Academy of Pediatrics. Thus, to cover the cost of their higher expected utilization, some carriers that offer child-rated products that are tiered by age categories typically charge their youngest enrollees a higher premium than children in other age groups. Two of the regional HMO carriers we reviewed divide children into two age groups: (1) birth through age 2 and (2) age 3 through age 18 or 19. In both cases, the youngest children were charged monthly premiums about $20 higher than the older age group. We also found that two of the carriers, both of which market specifically to children, do not cover children during their first 6 or 12 months due, in part, to the high costs of immunizations and well-child visits.

For the carriers in our study that offered child-rated products in three age categories, children aged 6 through 14 years typically had the lowest rates, while premium prices increased for older children—aged 15 through 19 years—to compensate for expected higher health costs during the teen years. Table 2 shows how carriers' rating methods affect the premium prices for a family with three children in different age groups living in Chicago, Illinois.

Table 2: Monthly Premium Differences Among Age Groups for Four Carriers Offering Coverage in Chicago, Illinois

Carrier	Plan type	Deductible	How rated	7 mos.	6 yrs.	15 yrs.
A	PPO	$250	Child-rated by age group	$114	$102	$131
B	PPO	250	Child-rated by age group	[a]	63	98
C	FFS	500	Single-child rate	142	142	142
D	FFS	2,500	Lowest adult rate[b]	103	71	71

[a]Carrier B does not cover children from birth to 12 months.

[b]The youngest child in the family is charged the lowest adult rate, while other children in the family are charged a lower, single-child rate.

Geographic Location and State Regulations

Premiums may also vary by geographic location, due largely to differences in physician and hospital costs as well as cost of living and state regulations. As table 1 illustrates, when Carrier B, Carrier C, and Carrier D are looked at across markets, consumers living in Omaha, Nebraska, are charged less for the same product than those living in Chicago, Illinois. For those carriers, depending on where the consumer resides, monthly premium rates ranged from $33 to $76 across the markets we reviewed. State regulations—guaranteed issue and rate restrictions, in particular—may also impact carriers' determinations of premium rates. For example, in Illinois, where there are no rate restrictions, a healthy 10-year-old could obtain coverage for $63 a month; that same child may pay $192 for coverage of similar benefits in Vermont—a state that has community rating, which requires carriers to set premiums at the same level for all plan participants, regardless of their age, gender, health status, or any other demographic characteristics.

Plan Type and Design

The plan type and design offered by the carrier is another factor that may affect the price of an individual health product. Plan types include traditional FFS, PPO, and HMO structures. Usually, the more willing an enrollee is to use selected providers that have negotiated charges for health services with the carrier, such as in PPOs and HMOs, the lower the premium an enrollee will have to pay. Similarly, the cost-sharing arrangement selected by the consumer also determines the price of an individual insurance product. Cost-sharing refers to the policyholder's contribution to the cost of the benefits received. Under traditional FFS plans, consumers pay an annual deductible and coinsurance up to a specified total limit on out-of-pocket expenses. HMOs typically require consumers to make copayments for each service rendered until an annual maximum is reached. The more potential out-of-pocket expenses the consumer could incur, the lower the premium usually will be. Child-only products that we examined included a wide range of cost-sharing alternatives. Deductibles for FFS and PPO plans typically ranged from $250 to $2,500; HMO copayments were typically $15 per physician visit and $100 to $500 per hospital admission.

Table 3 shows the difference in one carrier's premium prices for each of the plan types and deductible amounts ($250 and $500) it offers to a healthy 4-year-old in selected markets. In these markets, consumers would pay lower monthly premiums if they opted for the higher $500 deductible and the carrier's more restrictive PPO option.

Table 3: Examples of Variation in Monthly Premiums for a Healthy 4-Year-Old in Selected Markets Resulting From Different Plan Types and Deductible Amounts for One Child-Rated Carrier

	Cairo, Ill.		Jackson, Miss.		Zanesville, Ohio	
	Deductible		Deductible		Deductible	
Plan type	$250	$500	$250	$500	$250	$500
Hospital and physician PPO[a]	78	64	97	79	74	60
Hospital-only PPO[b]	88	72	107	88	82	67
FFS	107	87	130	106	97	79

[a]The hospital and physician PPO option steers enrollees to certain hospitals and physicians with whom the carrier has contracted prices for services. According to officials, this is the carrier's most popular plan in markets where a provider network is available.

[b]The hospital-only PPO option steers enrollees to certain hospitals; participants may select any physician.

The variation in premium rates attributable to different deductible amounts was also evident in the rates of a carrier in Oregon that we contacted. For this carrier, the monthly premium for the same individual product costs about $42, $70, or $98 a month, depending solely on whether the applicant opted for the $1,000, $500, or $200 deductible, respectively.

Medical Underwriting May Preclude Coverage for Children With Certain Health Conditions

While most children qualify for coverage at the standard rate, children with certain health conditions can be denied coverage, or their coverage may exclude an existing condition or treatment of certain parts of the body, or they may be charged a rate higher than the standard premium rate in states that allow medical underwriting.[8] Under medical underwriting, carriers may evaluate an applicant's health status on the basis of responses to a detailed health questionnaire. On these questionnaires, applicants may be required to indicate whether the child to be included on the policy has received medical advice or treatment of any kind within the child's lifetime or within a more limited time frame. Applicants may also be required to indicate whether the child has experienced a broad range of specifically identified symptoms, conditions, and disorders. Applicants may have to indicate whether the child has any pending treatments or surgery, is taking any prescription medication, or has ever been refused or canceled from another health or life insurance policy. On the basis of these responses, carriers may request additional information—typically medical records—or may require a physical examination.

The information obtained through this process may be used by carriers to determine whether to decline to cover the applicant altogether, accept the applicant but charge a higher than standard premium rate, or exclude from coverage an existing health condition or treatment of a part of the body. While the carriers we interviewed decline coverage to fewer child applicants than adult applicants, they still decline coverage to between 5 and 15 percent of child applicants.[9] Furthermore, as previously mentioned, two of the carriers we reviewed that market specifically to children told us that they do not cover children during their first 6 or 12 months of life due, in part, to the lack of information about a child's potential long-term health status.

Carriers may treat certain health conditions differently, so a consumer who is denied coverage due to a particular condition by one carrier may be able to find coverage from another carrier, possibly at a higher rate. (See

[8]Although medical underwriting results in the exclusion of individuals from the private insurance market, many carrier representatives and analysts suggest that it plays a key role in keeping insurance premiums more affordable for most individuals. (For additional information about medical underwriting and adverse selection, see GAO/HEHS-97-8, Nov. 25, 1996.) Recent state and federal initiatives may mitigate the effect of medical underwriting in many states. (For more information, see the appendix.)

[9]Some officials suggest that these declination rates could be understated since insurance agents will often deter individuals with a health condition from even applying for coverage from certain carriers. In addition, the declination rates do not take into account carriers that attach riders to policies to exclude certain health conditions, leaving children with only partial coverage.

fig. 1.) For example, Carrier A, Carrier B, and Carrier C decline coverage to applicants with juvenile diabetes, but Carrier D may offer these applicants coverage but at a higher premium. Similarly, a carrier's treatment of certain health conditions may vary depending on the severity and duration of the conditions. For example, Carrier D indicated that applicants with epilepsy could be (1) declined coverage altogether, (2) offered coverage but at a higher than standard premium rate, or (3) accepted for coverage at its standard rate. The criteria used to make these determinations vary among carriers and are considered proprietary.

Figure 1: Examples of How Selected Carriers May Treat Applicants With Certain Health Conditions

Health Condition	Carrier A	Carrier B	Carrier C	Carrier D
Anorexia and Bulimia	●	●	●	●
Asthma	◆	◆	◆ ■	▲
Attention Deficit Disorder	◆	◆	◆ ■	▲
Autism	●	●	●	●
Cerebral Palsy	●[a]	●	●	▲
Cystic Fibrosis	●[a]	●	●	●
Downs Syndrome	●[a]	●	●	●
Epilepsy	●[a]	●	◆ ■	▲ ◆
Emotional Disorders	●	●	◆ ■	▲
HIV Positive/AIDS	●	●	●	●
Juvenile Diabetes	●	●	●	▲
Leukemia	●	●	●	●
Muscular Dystrophy	●[a]	●	●	●
Rheumatoid Arthritis	●	●	●	■ ▲

● Carrier declines applicant for coverage.
◆ Carrier may accept applicant at the standard rate or decline applicant for coverage.
■ Carrier may accept applicant but exclude condition or decline applicant for coverage.
▲ Carrier may accept applicant but charge a higher premium rate or decline applicant for coverage.

[a] Carrier would not reject applicant based on the condition itself but may decline coverage due to other related symptoms.

Conclusions

Although comprehensive health insurance coverage is generally available for healthy children in the private individual market across the United States, consumers would do well to shop carefully for the child-only product that best meets their needs. Depending on multiple factors—such as where a child resides, the plan type selected, and the amount of out-of-pocket expenses the purchaser is willing to spend—premium prices vary substantially. In selected markets we reviewed, nearly half of the products had premiums priced at more than $80 a month for one child, making this an expensive purchase for some families.

Children who rely on the individual market for health insurance face problems similar to adults. Depending on where they live, premiums may be high relative to their family budget and choice of carriers and products may be limited. Furthermore, in many states, children—like adults—with certain health conditions may be charged a higher premium, have an existing health condition or part of the body excluded from coverage, or be denied coverage altogether.

External Comments

We provided a copy of this report draft to the American Association of Health Plans, BlueCross and BlueShield Association, and Health Insurance Association of America for their review and comment. Each offered clarifying and technical comments, which we incorporated as appropriate.

As agreed with your offices, we plan no further distribution of this report for 30 days. At that time, we will make copies of this report available on request. Please contact me at (202) 512-7114 if you or your staff have any further questions. This report was prepared by Mary W. Freeman, Susan T. Anthony, Randy M. DiRosa, and Betty J. Kirksey under the direction of Sheila K. Avruch.

Kathryn G. Allen

Kathryn G. Allen
Associate Director, Health Financing and
Systems Issues

Selected State and Federal Initiatives That May Mitigate the Effect of Medical Underwriting

Recent state and federal initiatives may have mitigated the effect of medical underwriting in many states in several ways. For example, 13 states that require all carriers to guarantee-issue one or more health plans to all applicants have effectively prohibited carriers from declining to provide coverage to applicants on the basis of their health status. In addition, 27 states have created high-risk insurance pools[10] to act as a safety net to ensure that otherwise uninsurable individuals can obtain coverage, although at a cost that is generally at least 50-percent higher than the average or standard rate charged in the individual insurance market for a comparable plan.

In addition to state-level initiatives, recently passed federal legislation also guarantees access to coverage to certain individuals. Under HIPAA, individuals who lose group coverage, exhaust their Consolidated Omnibus Budget and Reconciliation Act of 1985 (COBRA)[11] coverage or other continuation coverage available, and meet several additional criteria have guaranteed access to individual market coverage. Thus, a child who was covered as a dependent under a parent's group coverage (and who meets the eligibility criteria) typically would be eligible for HIPAA's guarantee of access to coverage. In contrast, a child who never had access to group coverage, because the parent's employer did not offer dependent coverage or any health coverage, would not be eligible for the access guarantee. Further, HIPAA's guarantee applies only to those losing group coverage—not to those who have always relied on the individual market for coverage. In addition, HIPAA does not explicitly restrict the premiums carriers may charge for this coverage.

[10]Alabama's high-risk pool is available only to individuals eligible under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

[11]COBRA applies to individuals leaving group health plans of 20 or more workers. Carriers are required to offer individuals leaving group coverage the option of continuing to purchase that coverage at no more than 102 percent of the total policy cost for 18 to 36 months.

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